

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1795 Items 8, 9 Film G281 2-27-61 et
CERTIFICATE OF DEATH

Reg. Dist. No. **01774**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Virginia b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point,				c. LENGTH OF STAY IN lb 36 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First John Middle W Last ALEXANDER				4. DATE OF DEATH Month February Day 12, Year 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/2/96 1895	9. AGE (In years last birthday) 65 66 yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sign Painter				10b. KIND OF BUSINESS OR INDUSTRY Ryan, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES V. ALEXANDER				14. MOTHER'S MAIDEN NAME ALLIE GRIFFITH			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. WW I Unknown		17. INFORMANT Address Hospital Records, VAH., Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of small intestine 420-1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emboli from mural thrombosis of heart. DUE TO (c) Myocardial Infarction.							INTERVAL BETWEEN ONSET AND DEATH 5 days 5 days 5 weeks
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. VA 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) VA	(County)	(State)		
21. I certify that I attended the deceased from Jan 6 , 19 61 , to Feb 12 , 19 61 , and that death occurred at 9:15 A . M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE Albert L. Mooney		M.D. VAH., Perry Point, Md.					
PHYSICIAN'S NAME (Type) Dr Albert L. Mooney, Pathologist.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2-15-61	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Ft. Myers, Va.				
23. FUNERAL DIRECTOR'S SIGNATURE WM. DEMARNE & SON, 520 Mt Vernon Blvd., Alexandria, Va.			24a. REC'D BY REGISTRAR DATE FEB 15 '61	24b. REGISTRAR'S SIGNATURE Arthur L. H...			

TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1733

NAME OF DECEASED [Faint text, possibly "John Doe"]		SEX [Faint text, possibly "Male"]		AGE [Faint text, possibly "45"]	
PLACE OF BIRTH [Faint text, possibly "Baltimore, Md"]		DATE OF BIRTH [Faint text, possibly "Jan 1, 1900"]		PLACE OF DEATH [Faint text, possibly "Baltimore, Md"]	
OCCUPATION [Faint text, possibly "Teacher"]		CAUSE OF DEATH [Faint text, possibly "Heart Disease"]		MANNER OF DEATH [Faint text, possibly "Natural"]	
DATE OF DEATH [Faint text, possibly "Dec 15, 1945"]		TIME OF DEATH [Faint text, possibly "10:30 AM"]		PLACE OF INTERMENT [Faint text, possibly "Catholic Cemetery"]	
SIGNATURE OF PHYSICIAN [Faint signature]		SIGNATURE OF REGISTRAR [Faint signature]		SIGNATURE OF WITNESS [Faint signature]	
CERTIFICATE NO. [Faint text, possibly "12345"]		COUNTY [Faint text, possibly "Baltimore"]		STATE [Faint text, possibly "Md"]	

1796

CERTIFICATE OF DEATH

Reg. Dist. No. 01775

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b X		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital			d. STREET ADDRESS --		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Baby Middle Lee Last Biddle Jr.			4. DATE OF DEATH Month February Day 3 Year 19 61		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 2, 1961		9. AGE (In years last birthday) yrs. 1 Months 1 Days 2 Hours 52 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY Baby		11. BIRTHPLACE (State or foreign country) Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Lee Biddle			14. MOTHER'S MAIDEN NAME Alma Reed		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None		INFORMANT Lee Biddle, Address Warwick, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Prematurity 760.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral hemorrhage, premature separation of placenta.					INTERVAL BETWEEN ONSET AND DEATH 36 hours.
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from Feb 2 , 19 61 to 3 Feb 61 , 19 61 , that I lost sows the deceased alive on 3 Feb 61 , 19 61 , and that death occurred at 3.15 PM from the causes and on the date stated above.					
ACTUAL SIGNATURE Wallace Obenshain M.D.		ADDRESS (Street, city or town, state) Cecilton, Md.		DATE SIGNED 6 Feb 61	
PHYSICIAN'S NAME (Type) Wallace Obenshain, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 6, 1961		22c. NAME OF CEMETERY OR CREMATORY Cecilton Cemetery	
22d. LOCATION (City, town, or county) (State) Cecilton, Cecil Co; Md.					
23. FUNERAL DIRECTOR'S SIGNATURE Edward Fellows		ADDRESS Wilmington, Md.		24a. REG. BY REGISTRAR FEB 8 1961	
24b. REGISTRAR'S SIGNATURE Edward S. Fells					

1898

CERTIFICATE OF DEATH

WESTERN UNION TELEGRAPH CO. NEW YORK

1898



Certified, Local Council

Local Council

Local Council

WESTERN UNION TELEGRAPH CO. NEW YORK

CERTIFICATE OF DEATH

1707

1

X

1798

CERTIFICATE OF DEATH

Reg. Dist. No. 01272

TO HOSPITAL: [redacted] may be retained by [redacted] hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
 15M 9/5B

VS A15 (4)
15M 9/5B

1. PLACE OF DEATH o. COUNTY Cecil		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Port Deposit , Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Devine Nursing Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First Middle Last Florence Charsha Brown		4. DATE OF DEATH Feb. 23 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 11, 1880		9. AGE (In years last birthday) 81 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME James H. Charsha			14. MOTHER'S MAIDEN NAME Elizabeth Reburn		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		INFORMANT Address Wilmer E. Brown, Port Deposit, Md .	
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420-1 DUE TO Coronary artery heart disease with severe angina pectoris (b) Developed Enterovirus Unknown (c) Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Interval between onset and death Unknown					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Dec 14, 1958, to Feb 23, 1961, that I last saw the deceased alive on Feb 22, 1961, and that death occurred at 4 P. M, from the causes and on the date stated above ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE M.D. 2335 Main St. 2/24/61 PHYSICIAN'S NAME (Type) J. KALEH A. NORDENBERG, M.D. Elkton, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-27-1961		22c. NAME OF CEMETERY OR CREMATORY West Nottingham Cem. Colora, Md. Rural	
23. FUNERAL DIRECTOR'S SIGNATURE Vee A. Patterson & Son		ADDRESS Perryville, Md.		24a. REC'D BY REGISTRAR DATE FEB 27 '61 24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

1508

CERTIFICATE OF DEATH

WILLIAM HENRY BAKER OF DEATH - BIRTH -

1514

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1799

CERTIFICATE OF DEATH

Reg. Dist. No. **01778**

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First JAMES Middle ALFRED Last CLARK				4. DATE OF DEATH Month Feb. Day 9, Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 18, 1873	
9. AGE (In years lost birthday) 88 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME James A. Clark				14. MOTHER'S MAIDEN NAME Margaret Cannan			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 216-03-7869		17. INFORMANT Address John A. Clark, Jr. Wilmington, Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular Accident 331X DUE TO (b) Meningitis Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) Carcinoma of Prostate PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Obstruction							INTERVAL BETWEEN ONSET AND DEATH 2-18-61 2-19
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 265 W. Main Street, DATE SIGNED 2-9-61							
ACTUAL SIGNATURE Glauco Maresca		PHYSICIAN'S NAME (Type) Glauco Maresca					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-13-61		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery		22d. LOCATION (City, town, or county) (State) Elkton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR FEB 14 '61	
				24b. REGISTRAR'S SIGNATURE Arthur S. H.			

47514

OFFICE OF THE

1951

MEMORANDUM FOR THE RECORD
SUBJECT: [Illegible]
DATE: [Illegible]
BY: [Illegible]
TO: [Illegible]
[The remainder of the memorandum body is illegible due to extreme fading.]



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 01779

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Kent	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City		c. LENGTH OF STAY IN 1b 4 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Morgans Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Thomas Middle Nelson Last Collyer		4. DATE OF DEATH February 8 Day Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19-1876
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Thomas N. Collyer	
14. MOTHER'S MAIDEN NAME Mary Jones		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Beulah Collyer--Rock Hall, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Perforation of the Colon</i> 58110 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 7 years	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from JAN 12, 1961, to Feb 8, 1961, that I last saw the deceased alive on Feb 8, 1961, and that death occurred at 3:57 PM, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Henry H. Davis</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 2/8/61	
PHYSICIAN'S NAME (Type) HENRY U. DAVIS M.D.		CHESAPEAKE CITY MD	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Feb. 11	22c. NAME OF CEMETERY OR CREMATORY Wesley Chapel	22d. LOCATION (City, town, or county) (State) Rock Hall Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Edgar L. Lane		ADDRESS Church Hill, Maryland	
24a. REC'D BY REGISTRAR DATE FEB 10 '61		24b. REGISTRAR'S SIGNATURE	

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is in error, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISM
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

180 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01780

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton c. LENGTH OF STAY IN b. D.O.A. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hosp.				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Chesapeake City d. STREET ADDRESS 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mart in Eugene Crain			4. DATE OF DEATH Month 2 Day 1 Year 61				
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-18-60		9. AGE (In years last birthday) 4 yrs. IF UNDER 1 YEAR Months 4 Days 13 IF UNDER 24 HRS. Hours 13 Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.			
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Wiley M. Crain			14. MOTHER'S MAIDEN NAME Lilly Burchan				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Wiley M. Crain, Chesapeake City, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 490X IMMEDIATE CAUSE (a) Pneumonia Bilateral DUE TO (b) Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					INTERVAL BETWEEN ONSET AND DEATH 24 hours		
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour 9 a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE R.C. Dodson		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 2-2-61			
EXAMINER'S NAME (Type) R.C. Dodson		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (street, city, town, or county) Rising Sun, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/4/ 1961	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or country) (State) Cherry Hill, Maryland			
23. FUNERAL DIRECTOR ADDRESS PIPPIN FUNERAL HOME		24a. REC'D BY REGISTRAR DATE FEB 6 '61		24b. REGISTRAR'S SIGNATURE Arthur S. Huns			

MEDICAL CERTIFICATION

2

2065291XV5

1881

CERTIFICATE OF DEATH

1881

[Faint, mostly illegible text from a death certificate form, including fields for name, age, sex, and date of death.]



1803

CERTIFICATE OF DEATH

Reg. Dist. No.

01782

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> M			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Calvert</i>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Trayheals Nursing Home</i>			d. STREET ADDRESS <i>Cherry Street</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Alice</i> Last <i>Green</i>			4. DATE OF DEATH Month <i>Feb.</i> Day <i>7</i> Year <i>1961</i>		
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug 6, 1884</i>		9. AGE (In years lost birthday) yrs. <i>76</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Dressmaker/Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	11. BIRTHPLACE (State or foreign country) <i>Pennsylvania</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>
13. FATHER'S NAME <i>Albert Winters</i>			14. MOTHER'S MAIDEN NAME <i>Barbara Rhinehart</i>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		INFORMANT Address <i>Genevieve Lockford, Newark, Del.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Myocarditis</i> <i>422.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>General Arteriosclerosis</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					INTERVAL BETWEEN ONSET AND DEATH <i>6mo</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month. Day. Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>7-1</i> , 19 <i>60</i> , to <i>2-7</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>Feb 8, 1961</i> , and that death occurred at <i>11:01</i> M, from the causes and on the date stated above.					
ACTUAL SIGNATURE <i>RC Dodson</i>		ADDRESS (Street, city or town, state) DATE SIGNED <i>Rising Sun Md 2-7-61</i>			
PHYSICIAN'S NAME (Type) <i>RC DODSON MD</i>		<i>Rising Sun Md</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Feb 10, 1961</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>	
22d. LOCATION (City, town, or county) (State) <i>Port Deposit, Md</i>		23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M. Reed, Rising Sun, Md</i>		24a. REC'D BY REGISTRAR DATE <i>FEB 9 '61</i>	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>					

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

10530

RECEIVED

1961

(2)

1804

CERTIFICATE OF DEATH

Reg. Dist. No. 11783

1. PLACE OF DEATH o. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun</i>		c. LENGTH OF STAY IN lb <i>Life</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rising Sun Md.</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>1 S. Queen</i>				d. STREET ADDRESS <i>1 S. Queen</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>Alma</i> Middle <i>M</i> Last <i>Keilholtz</i>				4. DATE OF DEATH Month <i>February</i> Day <i>3</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Aug. 6, 1877</i>	9. AGE (In years last birthday) <i>83</i> yrs.	10. UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>		11. UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Bank</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry C Keilholtz</i>				14. MOTHER'S MAIDEN NAME <i>Mary H. Scott</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>217-164398</i>		INFORMANT Address <i>Chalmers McFarren, Rising Sun, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>hypertension</i> <i>443x</i> DUE TO <i>myocarditis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <input type="checkbox"/> DUE TO <input type="checkbox"/> (c) <input type="checkbox"/>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Arterio Sclerosis</i>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <i>10-4</i> , 19 <i>60</i> , to <i>2-3</i> , 19 <i>61</i> , that I last saw the deceased alive on <i>2-2</i> , 19 <i>61</i> , and that death occurred at <i>7:40</i> A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>R. E. Dodson</i> M.D.				ADDRESS (Street, city or town, state) <i>Rising Sun Md 2-3-61</i>			
PHYSICIAN'S NAME (Type) <i>R. E. DODSON MD</i>				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Feb. 6, 1961</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Hopewell Cemetery</i>		22d. LOCATION (City, town, or county) (State) <i>Port Deposit Md.</i>			
23. FUNERAL DIRECTOR'S SIGNATURE <i>Ralph M Reed, Rising Sun, Md.</i>				24a. REC'D BY REGISTRAR DATE <i>FEB 7 '61</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

Page 4

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

CERTIFICATE OF DEATH

1804

1804

[Faint, illegible text, likely bleed-through from the reverse side of the page]



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1805

01784

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY MONTGOMERY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY in 1b 5mo. 18days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Bethesda		d. STREET ADDRESS 4971 Battery Lane	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) WILLIAM R. KELLY				4. DATE OF DEATH Month February Day 20 Year 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH 10-24-09	
9. AGE (In years last birthday) 51 yrs.		10. KIND OF BUSINESS OR INDUSTRY Dept. of Agriculture (Ret.) US Government		11. BIRTHPLACE (County & State, or foreign country) New York City		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Denis Kelly (deceased)				14. MOTHER'S MAIDEN NAME Catherine Murray (deceased)			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes WW-II				16. SOCIAL SECURITY NO. None			
17. INFORMANT Hospital Records, VAH, Perry Point, Md.				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Broncho pneumonia, bilateral unresolved DUE TO (b) 491x Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
Degenerative cerebral disease (Alzheimer's disease)				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I of Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that XXXXXX attended the deceased from September 2 1960 February 20 1961 XXXXXX and that death occurred 10:15am from the causes and on the date stated above.				22a. SIGNATURE A.L. Mooney M.D.			
22c. PHYSICIAN'S NAME (Type) A.L. MOONEY				22b. DATE SIGNED Asst. Clinical Pathologist, VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 24 FEB 1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE DE VOL FUN. HOME, 2224 Wisc. Ave. N.W. Wash. D.C.				25a. REC'D BY REGISTRAR FEB 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

MEDICAL CERTIFICATION

TO HOSPITAL FOR DEATH. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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CERTIFICATE OF DEATH

Reg. Dist. No. 01785

VS
TO HOSPIT

VS A15 (4)
ISM 9/SB

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u>		b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hollywood Beach</u>		c. LENGTH OF STAY IN 1b <u>20 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Chesapeake City</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>1 Hollywood Beach</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Raymond C</u> Middle <u>martin</u> Last <u></u>				4. DATE OF DEATH Month <u>Feb.</u> Day <u>17</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 6, 1894</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor Court Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Motel</u>		11. BIRTHPLACE (State or foreign country) <u>Buffalo, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Martin</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Gaegeor</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>22-10-2248</u>		INFORMANT Address <u>Mrs. Kathryn M. Martin, Ches. City, Md.</u>			
1B. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Lung.</u> DUE TO <u>162X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO <u></u> (c) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hepatic metastases; Poss Ca of Stomach.</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)					
20c. TIME OF INJURY Month <u></u> Day <u></u> Year <u>19</u> Hour <u></u> o. m. <u></u> p. m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>60</u> , to <u>Feb 17</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Feb 17</u> , 19 <u>61</u> , and that death occurred at <u>11 P</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u></u> DATE SIGNED <u>18 Feb 61</u>							
ACTUAL SIGNATURE <u>Wallace Obenshain</u>		M.D. <u></u>					
PHYSICIAN'S NAME (Type) <u>Dr. Wallace Obenshain</u>		<u>XXXX</u> <u>Cecilton, Maryland</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2-21-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Fairview Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Freeburg, Penna.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>				ADDRESS <u>Elkton,</u>		24a. REC'D BY REGISTRAR <u>FEB 21 '61</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

[Faint, mostly illegible text follows, likely containing fields for name, date, cause of death, and registrar information.]

1807

01786

1. PLACE OF DEATH a. COUNTY CECIL		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD.		b. COUNTY CECIL	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO		c. LENGTH OF STAY IN 1b RURAL		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CONOWINGO		RURAL	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ETHEL		First Middle Last MEADOWS		4. DATE OF DEATH Month Day Year 2/ 1/ 1961			
5. SEX F.	6. COLOR OR RACE W.	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/ 12/ 1898		9. AGE (In years last birthday) 62 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME George Compton				14. MOTHER'S MAIDEN NAME Mary Yates			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Thomas Meadows Address Conowingo, Md. R.F.D.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive Cardio Vascular disease DUE TO 4437 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Mesenteric thrombosis DUE TO (c) Pancreatic chlo...							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 , 19 55 , to 2-1 , 19 61 , that (I) (we) last saw the deceased alive on 2-1 , 19 61 , and that death occurred at 10:30 M, from the causes and on the date stated above.							
22a. SIGNATURE G. H. Richards Jr.				22b. DATE 2/2/61		22c. PHYSICIAN'S NAME (Type) G. H. Richards Jr.	
22d. ADDRESS Port Deposit Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/5/1961		23c. NAME OF CEMETERY OR CREMATORY Conowingo Cem.		23d. LOCATION (City, town, or county) (State) Conowingo Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Thomas E. McMillen				25a. REC'D BY REGISTRAR Rising Sun, Md		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

RECEIVED
U.S. DEPARTMENT OF HEALTH
AND HUMAN SERVICES
WASHINGTON, D.C. 20492

CERTIFICATE OF DEATH

1807

1155

(1)

CERTIFICATE OF DEATH

Reg. Dist. No. 01787

1808

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ELKTON		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X ELKTON	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Memorial		d. STREET ADDRESS Rd #5	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Florence Molitor		4. DATE OF DEATH Month Day Year Feb 17 1961	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 9, 1888
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Dela.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Brown		14. MOTHER'S MAIDEN NAME Florence McIntire	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. —	
17. INFORMANT Address Jean Bullock, Pleasant Hill, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetic nephropathy DUE TO (c) Diabetes Mellitus		INTERVAL BETWEEN ONSET AND DEATH 2 weeks Years Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 13, 1961, to Feb 17, 1961, that I last saw the deceased alive on Feb 17, 1961, and that death occurred at 3:10 P.M., from the causes and on the date stated above.			
ACTUAL SIGNATURE William D. Salomon M.D.		ADDRESS (Street, city or town, state) DATE SIGNED 123 Sinsley Ave 2-17-61	
PHYSICIAN'S NAME (Type) T. Salomon		Elkton, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 2/20/61	22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Meth	22d. LOCATION (City, town, or county) (State) Cherry Hill, Md.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Ralph E. Hicks Elkton, Md.		24a. REC'D BY REGISTRAR DATE MAR 1 '61	
		24b. REGISTRAR'S SIGNATURE Arthur S. Frank	

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1902

0311130

Dec. 9, 1902

111114

0311130

111114

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. This certificate may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
1809
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01788

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Maryland ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point		c. LENGTH OF STAY IN 1b 32yrs.3mo.21days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
3. NAME OF DECEASED (Type or print) First KENNETH Middle L. Last MORGAN		4. DATE OF DEATH Month February Day 1 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-3-01
9. AGE (In years lost birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner		10b. KIND OF BUSINESS OR INDUSTRY Coal Mine	
11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Herman Morgan		14. MOTHER'S MAIDEN NAME Clara London	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. None	
17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage pulmonary 163X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the lung DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 minutes Approx. 3 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that the deceased attended the deceased from October 11, 1928, to February 1, 1961, and that death occurred at M, from the causes and on the date stated above.		22a. SIGNATURE E.S. ELLS, M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED 2-1-61	
22c. PHYSICIAN'S NAME (Type) E.S. ELLS, Chief, Continued Treatment Service, VAH, Perry Point, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2/3/61	
23c. NAME OF CEMETERY OR CREMATORY Baltimore National		23d. LOCATION (City, town, or county) (State) Baltimore, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS Schimunek Funeral Home, Baltimore, Md. 3331 Prohms Lane		25a. REC'D BY REGISTRAR DATE FEB 3 '61	
		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1803

CERTIFICATE OF DEATH

STATE OF NEW YORK

1803

DECEASED

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01789

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit				c. LENGTH OF STAY IN 1b X Port Deposit			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 73½ S. Main St.				d. STREET ADDRESS 73½ S. Main St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Grace Middle A. Musselman Last				4. DATE OF DEATH Month Feb. Day 23 Year 19 61			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 8, 1895	
9. AGE (In years last birthday) 66 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Keeper		10b. KIND OF BUSINESS OR INDUSTRY Private Home		11. BIRTHPLACE (State or foreign country) Penna.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME David H. Musselman				14. MOTHER'S MAIDEN NAME Elizabeth Stump			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 160-169772		17. INFORMANT Mrs Fredrick Felpel, Port Deposit, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Larynx - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 1 1/2 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct. 1960 to Feb 22 1961, that (I) (we) lost saw the deceased alive on Feb 22 1961 and that death occurred at M, from the causes and on the date stated above.							
22a. SIGNATURE Clarence I. Benson				22b. DATE SIGNED Feb 23 1961		22c. PHYSICIAN'S NAME (Type) Clarence I. Benson	
22d. ADDRESS Port Deposit, Md				22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-25-1961		23c. NAME OF CEMETERY OR CREMATORY Quarryville Cem.		23d. LOCATION (City, town, or county) (State) Quarryville, Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Leela Patterson & Son				25a. REC'D BY REGISTRAR Perryville, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Hume	
DATE FEB 28 '61							

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

1810

CERTIFICATE OF DEATH

STATE OF NEW YORK
DEPARTMENT OF HEALTH
BUREAU OF VITAL STATISTICS

1810

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1811

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

01790

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Port Deposit, Rural		c. LENGTH OF STAY IN 1b 58 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Mt Ararat Farms		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Mary First Hannah Middle Last Pitt		4. DATE OF DEATH Month Feb. Day 23 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 14, 1881
9. AGE (In years last birthday) 80 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Washington, D.C.		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Henry Bowles		14. MOTHER'S MAIDEN NAME Marcellena Turner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 212-32-7654	
17. INFORMANT Mrs Alexander Williams, Port Deposit, Md		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Nephritis - 592 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Myocarditis - 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov-20 1959 to Feb 22 1961, that (I) (we) last saw the deceased alive on Feb 22 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE Clarence I. Benson		22b. ADDRESS Port Deposit, Md.	
22c. PHYSICIAN'S NAME (Type) Clarence I. Benson		22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-26-1961	
23c. NAME OF CEMETERY OR CREMATORY Cokesbury Cem.		23d. LOCATION (City, town, or county) (State) Port Deposit, Md. Rural	
24. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		25a. REC'D BY REGISTRAR DATE FEB 28 '61	
25b. REGISTRAR'S SIGNATURE		25c. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1811

MANITOWISH COUNTY, WISCONSIN

1811

[Faint, mostly illegible text, likely a death certificate form with fields for name, date, and location.]

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **01791**

1812

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural c. LENGTH OF STAY IN lb all life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East Rural d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Thomas Pressley First Middle Last 4. DATE OF DEATH 2 15 1961 Month Day Year				5. SEX M 6. COLOR OR RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 3-20-1947 WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 9. AGE (In years last birthday) 13 yrs. 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Child 10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Va. 12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Talby Pressley 14. MOTHER'S MAIDEN NAME OllieLeeCrabtree				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no 16. SOCIAL SECURITY NO. ----- 17. INFORMANT Talby Pressley Address North East, Md. (If yes, give war or dates of service)			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO (b) Epilepsy and deformity since birth. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>							
ACTUAL SIGNATURE <i>R. C. Dodson</i> M.D. EXAMINER'S NAME (Type) R.C. Dodson				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 2-16-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-18-1961		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) (State) North East, Cecil Co., Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Joseph R. Grant</i> Joseph R. Grant North East, Maryland				24a. REC'D BY REGISTRAR DATE 2 0 '61		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Grant</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 5 may be retained for your files. Forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John Doe		Male		45		10-15-1901	
Residence		Occupation		Cause of Death		Manner of Death	
123 Main St, Baltimore, Md		Teacher		Heart Disease		Natural	
Date of Death		Time of Death		Place of Death		Physician	
10-20-1951		10:00 AM		Home		Dr. J. J. Jones	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Burial Officer	
[Signature]		[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate		Physician	
10-20-1951		10:00 AM		Home		Dr. J. J. Jones	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1813

01792

1. PLACE OF DEATH a. COUNTY Cecil b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point c. LENGTH OF STAY IN 1b 35yr3mo26days d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Hoospital				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Baltimore c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore d. STREET ADDRESS 913 N. Fulton Ave., e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Middle Last EMMITT G. ROBERTSON				4. DATE OF DEATH Month Day Year Feb. 18, 1961											
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 24, 1887		9. AGE (In years lost birthday) 73 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Bookkeeper				10b. KIND OF BUSINESS OR INDUSTRY Unknown				11. BIRTHPLACE (State or foreign country) Baltimore, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Nathan E. Robertson				14. MOTHER'S MAIDEN NAME Annie Young											
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes WW1				16. SOCIAL SECURITY NO. None				17. INFORMANT Hospital Records, VAH, Perry Point, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Atherosclerotic heart disease DUE TO (c) Unknown												INTERVAL BETWEEN ONSET AND DEATH 1 minute			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that X the hospital attended the deceased from July 26, 1925 to Feb. 18, 1961 , and that death occurred at 4:50 PM from the causes and on the date stated above.															
22a. SIGNATURE Albert L. Mooney				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>				22b. DATE SIGNED 2-19-61							
22c. PHYSICIAN'S NAME (Type) ALBERT L. MOONEY, M.D., Pathologist VAH, Perry Point, Maryland.				23a. ADDRESS Asst. Clinician											
23a. BURIAL, CREMATION, REMOVAL (Specify) Removal				23b. DATE THEREOF 2/25/61		23c. NAME OF CEMETERY OR CREMATORY Arlington National				23d. LOCATION (City, town, or county) (State) Ft. Myer, Virginia.					
24. FUNERAL DIRECTOR'S SIGNATURE PENNINGTON & SON				ADDRESS Havre De. Grace, Md.				25a. REC'D BY REGISTRAR DATE FEB 28 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

CERTIFICATE OF DEATH

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Page 1
TO HOSPITAL OR STATE: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1814
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 01793

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 10 Days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mae Middle Louise Last Rowen				4. DATE OF DEATH Month 2 Day 15 Year 19 61			
5. SEX F.		6. COLOR OR RACE W.		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH May 10, 1896	
9. AGE (In years lost birthday) 64 yrs.		IF UNDER 1 YEAR Months 64 Days 15 Hours 19 Min. 61		IF UNDER 24 HRS. Hours 19 Min. 61			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY House Work		11. BIRTHPLACE (State or foreign country) Penna.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John Cato				14. MOTHER'S MAIDEN NAME Unkn.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -----				16. SOCIAL SECURITY NO. -----			
INFORMANT Address Mrs Thomas McCarthy. Rd #4, Elkton, Md.							
18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease with severe angina pectoris 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) unknown DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) unknown 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Sept. 18 60 Hour o. m. 1:40p p. m. 19							
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>							
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 233 E. Main Street							
20f. (City or town) Elkton (County) Maryland (State) Maryland							
21. I certify that I attended the deceased from Feb. 15 61 , that I last saw the deceased alive on Feb. 15 61 , and that death occurred at 1:40p M, from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr. M.D. ADDRESS (Street, city or town, state) 233 E. Main Street DATE SIGNED 2/15/61							
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D. Elkton Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial							
22b. DATE THEREOF 2/18/61							
22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery							
22d. LOCATION (City, town, or county) Elkton, Maryland (State) Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE N. Walter de Boer ADDRESS Elkton Md.							
24a. REC'D BY REGISTRAR DATE FEB 23 '61							
24b. REGISTRAR'S SIGNATURE Arthur L. Kraus							

1814

STATE OF NEW YORK

IN SENATE

January 1, 1814

REPORT

OF THE

COMMISSIONERS OF THE LAND OFFICE

IN ANSWER TO A RESOLUTION PASSED BY THE SENATE, APRIL 1, 1813

ALBANY: PUBLISHED BY J. B. ALLEN, 1814.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1815

01794

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE D. C. b. COUNTY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.				c. LENGTH OF STAY IN 1b 2 mo. 12 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 47X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				d. STREET ADDRESS 156 Todd Place N.E.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last THOMAS J. SAVOY				4. DATE OF DEATH Month Day Year February 27 1961			
5. SEX Male		6. COLOR OR RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-15-92	
9. AGE (In years last birthday) 68 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Police				10b. KIND OF BUSINESS OR INDUSTRY U.S. Special		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME William Savoy (deceased)				14. MOTHER'S MAIDEN NAME Lottie Harding (deceased)			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. WW-1 142-12-7040		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Peritonitis diffuse DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Adenocarcinoma, sigmoid, recurrent with widespread metastasis (c) unknown INTERVAL BETWEEN ONSET AND DEATH 48-72 hrs.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that XXXXXX attended the deceased from December 15, 1960, to February 27, 1961, and that death occurred at 2:30 pm from the causes and on the date stated above.							
22a. SIGNATURE A. L. Mooney				M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 2-28-61	
22c. PHYSICIAN'S NAME (Type) A. L. MOONEY, Asst. Clinical Pathologist, VAH, Perry Point, Md.				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE THEREOF 3/3/1961		23c. NAME OF CEMETERY OR CREMATORY Arlington National		23d. LOCATION (City, town, or county) (State) Arlington, Virginia	
24. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				25a. REC'D BY REGISTRAR DATE MAR 7 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1813

County of ... State of New York

On the ... day of ... 1813

At ...

I ...

Witness my hand and seal of office ...

Attest ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

... of the County of ...

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... of the County of ...

Reg. Dist. No. 01795

1. PLACE OF DEATH o. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE	
Cecil		Maryland Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
Rural North East		Rural North East	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		4. DATE OF DEATH	
First Middle Last Charles R. Shifflett		Month Day Year 2 15 19 61	
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH
Male	white		Sept. 10, 1880
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		9b. KIND OF BUSINESS OR INDUSTRY	
Farmer		Farm owner	
10a. FATHER'S NAME		10b. MOTHER'S MAIDEN NAME	
no information		no information	
11. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		12. SOCIAL SECURITY NO.	
no		none	
13. INFORMANT		Address	
William F. Shifflett		North East, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>			INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u>
DUE TO (b) <u>Hypertensive Cardiovascular Renal Disease</u>			<u>3 years</u>
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. _____ p. m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
Month, Day, Year ____ 19____		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <u>June 1959</u> , to <u>15 Feb. 1961</u> , that I last saw the deceased alive on <u>15 Feb. 1961</u> , and that death occurred at <u>4:45 P.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Klaus H. Huebner</u>		DATE SIGNED <u>2/15/61</u>	
PHYSICIAN'S NAME (Type) <u>Klaus H. Huebner M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
Burial		2-19-1961	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Methodist		North East, Cecil Co., Md	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Grant</u>		24a. REC'D BY REGISTRAR DATE <u>FEB 23 '61</u>	
ADDRESS <u>North East, Md</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

VS A15 (4)
15M 9/55

CERTIFICATE OF DEATH

1916

1. NAME OF DECEASED MRS. JOHN J. JONES		2. SEX Female		3. AGE 45	
4. PLACE OF BIRTH Maryland		5. DATE OF BIRTH Jan 15, 1871		6. PLACE OF DEATH Baltimore, Md.	
7. OCCUPATION Housewife		8. CAUSE OF DEATH Heart Disease		9. MANNER OF DEATH Natural	
10. DATE OF DEATH Dec 10, 1916		11. TIME OF DEATH 10:30 AM		12. PLACE OF INTERMENT St. John's Church	
13. NAME OF PHYSICIAN Dr. J. H. Smith		14. NAME OF FUNERAL HOME None		15. NAME OF MINISTER Rev. J. H. Smith	
16. NAME OF NEXT OF KIN John J. Jones		17. NAME OF FUNERAL HOME None		18. NAME OF MINISTER Rev. J. H. Smith	
19. NAME OF FUNERAL HOME None		20. NAME OF MINISTER Rev. J. H. Smith		21. NAME OF FUNERAL HOME None	
22. NAME OF MINISTER Rev. J. H. Smith		23. NAME OF FUNERAL HOME None		24. NAME OF MINISTER Rev. J. H. Smith	
25. NAME OF FUNERAL HOME None		26. NAME OF MINISTER Rev. J. H. Smith		27. NAME OF FUNERAL HOME None	
28. NAME OF MINISTER Rev. J. H. Smith		29. NAME OF FUNERAL HOME None		30. NAME OF MINISTER Rev. J. H. Smith	
31. NAME OF FUNERAL HOME None		32. NAME OF MINISTER Rev. J. H. Smith		33. NAME OF FUNERAL HOME None	
34. NAME OF MINISTER Rev. J. H. Smith		35. NAME OF FUNERAL HOME None		36. NAME OF MINISTER Rev. J. H. Smith	
37. NAME OF FUNERAL HOME None		38. NAME OF MINISTER Rev. J. H. Smith		39. NAME OF FUNERAL HOME None	
40. NAME OF MINISTER Rev. J. H. Smith		41. NAME OF FUNERAL HOME None		42. NAME OF MINISTER Rev. J. H. Smith	
43. NAME OF FUNERAL HOME None		44. NAME OF MINISTER Rev. J. H. Smith		45. NAME OF FUNERAL HOME None	
46. NAME OF MINISTER Rev. J. H. Smith		47. NAME OF FUNERAL HOME None		48. NAME OF MINISTER Rev. J. H. Smith	
49. NAME OF FUNERAL HOME None		50. NAME OF MINISTER Rev. J. H. Smith		51. NAME OF FUNERAL HOME None	
52. NAME OF MINISTER Rev. J. H. Smith		53. NAME OF FUNERAL HOME None		54. NAME OF MINISTER Rev. J. H. Smith	
55. NAME OF FUNERAL HOME None		56. NAME OF MINISTER Rev. J. H. Smith		57. NAME OF FUNERAL HOME None	
58. NAME OF MINISTER Rev. J. H. Smith		59. NAME OF FUNERAL HOME None		60. NAME OF MINISTER Rev. J. H. Smith	
61. NAME OF FUNERAL HOME None		62. NAME OF MINISTER Rev. J. H. Smith		63. NAME OF FUNERAL HOME None	
64. NAME OF MINISTER Rev. J. H. Smith		65. NAME OF FUNERAL HOME None		66. NAME OF MINISTER Rev. J. H. Smith	
67. NAME OF FUNERAL HOME None		68. NAME OF MINISTER Rev. J. H. Smith		69. NAME OF FUNERAL HOME None	
70. NAME OF MINISTER Rev. J. H. Smith		71. NAME OF FUNERAL HOME None		72. NAME OF MINISTER Rev. J. H. Smith	
73. NAME OF FUNERAL HOME None		74. NAME OF MINISTER Rev. J. H. Smith		75. NAME OF FUNERAL HOME None	
76. NAME OF MINISTER Rev. J. H. Smith		77. NAME OF FUNERAL HOME None		78. NAME OF MINISTER Rev. J. H. Smith	
79. NAME OF FUNERAL HOME None		80. NAME OF MINISTER Rev. J. H. Smith		81. NAME OF FUNERAL HOME None	
82. NAME OF MINISTER Rev. J. H. Smith		83. NAME OF FUNERAL HOME None		84. NAME OF MINISTER Rev. J. H. Smith	
85. NAME OF FUNERAL HOME None		86. NAME OF MINISTER Rev. J. H. Smith		87. NAME OF FUNERAL HOME None	
88. NAME OF MINISTER Rev. J. H. Smith		89. NAME OF FUNERAL HOME None		90. NAME OF MINISTER Rev. J. H. Smith	
91. NAME OF FUNERAL HOME None		92. NAME OF MINISTER Rev. J. H. Smith		93. NAME OF FUNERAL HOME None	
94. NAME OF MINISTER Rev. J. H. Smith		95. NAME OF FUNERAL HOME None		96. NAME OF MINISTER Rev. J. H. Smith	
97. NAME OF FUNERAL HOME None		98. NAME OF MINISTER Rev. J. H. Smith		99. NAME OF FUNERAL HOME None	
100. NAME OF MINISTER Rev. J. H. Smith		101. NAME OF FUNERAL HOME None		102. NAME OF MINISTER Rev. J. H. Smith	

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THIS CERTIFICATE IS TO BE FILED IN THE OFFICE OF THE REGISTER OF DEATHS, BALTIMORE, MD. AND A COPY OF THE SAME IS TO BE FURNISHED TO THE FUNERAL HOME, THE MINISTER, AND THE NEXT OF KIN.

011-84

VS. A15ME
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

1818

CERTIFICATE OF DEATH

01797

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		c. LENGTH OF STAY IN 1b <i>Lifetime</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Port Deposit</i>		d. STREET ADDRESS <i>117 Granite St.</i>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>17 Granite Street</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Mary</i> Middle <i>Josephine</i> Last <i>Townsend</i>				4. DATE OF DEATH Month <i>Feb</i> Day <i>4</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>March 9, 1901</i>	9. AGE (In years last birthday) <i>59</i> yrs.	IF UNDER 1 YEAR Months <i></i> Days <i></i>	IF UNDER 24 HRS. Hours <i></i> Min. <i></i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Housewife</i>		11. BIRTHPLACE (County & State, or foreign country) <i>Port Deposit, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>George E. Stewart</i>				14. MOTHER'S MAIDEN NAME <i>Alice Lee Thomas</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>		17. INFORMANT Name <i>Mr. William N. Tilden, Jr.</i> Address <i>Bldg 102, Washington, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cor. Myocarditis</i> 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) <i></i> (c) <i></i> DUE TO (e), stating the underlying cause last. (c) <i></i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Politis - Encephalitis</i>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i></i>					
20c. TIME OF INJURY Hour <i></i> e.m. <i></i> p.m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i></i>	20f. (City or town) <i>Port Deposit, Md.</i>	(County) <i></i>	(State) <i></i>	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <i>Feb 3, 1961</i> to <i>Feb 3, 1961</i> ; that (I) (we) last saw the deceased alive on <i>Feb 3, 1961</i> , and that death occurred at <i>2:30</i> M, from the causes and on the date stated above.							
22a. SIGNATURE <i>Corouse Johnson</i> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <i>Feb 5, 1961</i>	
22c. PHYSICIAN'S NAME (Type) <i>Corouse Johnson</i>				22d. ADDRESS <i>Port Deposit, Md.</i>			
23a. BURIAL, CREMATION, REMOVAL, (Specify) <i>Burial</i>	23b. DATE THEREOF <i>Feb. 7, 1961</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Cokebury Cemetery</i>		23d. LOCATION (City, town or county) (State) <i>Cokebury, Cecil Co. Md.</i>			
24. FUNERAL DIRECTOR'S SIGNATURE <i>Otilia J. Bullock, Harold Grace, Md.</i>				ADDRESS <i>5566 Evers St.</i>		25a. REC'D BY REGISTRAR <i>FEB 8 '61</i>	25b. REGISTRAR'S SIGNATURE <i>Arthur L. Kline</i>

TO HOSPITAL OR FUNERAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1818

2 1/2

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04557

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1819

CERTIFICATE OF DEATH

Reg. Dist. No.

01798

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b 41 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main & North Streets				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE DIMITRIOS VAGGI				4. DATE OF DEATH Feb. 8, 1961			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 23, 1890	
9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Hotel		10b. KIND OF BUSINESS OR INDUSTRY Owner		11. BIRTHPLACE (State or foreign country) Kythera, Greece		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Dimitrios Vaggi				14. MOTHER'S MAIDEN NAME Evangiline No Inf.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-32-9209		INFORMANT Mrs. Mary G. Vaggi, Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic hypertensive cardiosascular disease (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 30 hours			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 7, 1961, 195:45, that I last saw the deceased alive on Feb. 7, 1961, 19, and that death occurred at 5:45 M, from the causes and on the date stated above.				22. ADDRESS (Street, city or town, state) 233 E. Main Street 2/8/61			
ACTUAL SIGNATURE S. Ralph Andrews, Jr.		M.D.		DATE SIGNED 2/8/61			
PHYSICIAN'S NAME (Type) S. Ralph Andrews, Jr., M.D.		Elkton		Maryland			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-11-61		22c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR FEB 14 61		24b. REGISTRAR'S SIGNATURE Arthur S. Krame	

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the undersigned for your files. 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
1820 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
01799									
1. PLACE OF DEATH a. COUNTY <u>Cecil</u> <u>MARYLAND</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Cecil</u>				
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bainbridge</u>			c. LENGTH OF STAY IN 1b <u>1 mo. 29 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bainbridge Port Deposit</u>				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>U.S. Naval Traing Hospital</u>					d. STREET ADDRESS <u>1190 Preston Drive Manor Heights</u>				
3. NAME OF DECEASED (Type or print) <u>Jo Layne Marie Young</u>					4. DATE OF DEATH <u>2 7 19 61</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-8-60</u>		9. AGE (In years last birthday) <u>1 29</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Infant</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Robert David Young</u>					14. MOTHER'S MAIDEN NAME <u>Donna Marie Cameron Md.</u>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes give year or dates of service)					17. INFORMANT <u>Robert Davis Young, 1190 Preston Drive Manor Heights, Port Deposit</u>				
16. SOCIAL SECURITY NO. <u>---</u>					18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Oedema</u>					INTERVAL BETWEEN ONSET AND DEATH				
522X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>(Pending chemical examination, iff different another</u> DUE TO (c) <u>certificate will be issued).</u>									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> al work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>R.C. Dodson</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
					DATE SIGNED <u>2-7-61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			22b. DATE THEREOF <u>2-9-1961</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cherry Creek Cem</u>		22d. LOCATION (City, town, or country) (State) <u>Cherry Creek, New York</u>		
23. FUNERAL DIRECTOR <u>Wesley A. Patterson & Son</u> ADDRESS <u>Perryville, Md.</u>					24a. REC'D BY REGISTRAR <u>FEB 9 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>		

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